FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013920

Facility Name: St. Paul's Home

Address: P.O. Box 347, 1021 West "E" Street (Number) Belleville (City) 62222-0347 (Zip Code)

County: St. Clair

Telephone Number: (618)233-2095 **Fax #** (618)233-2109

IDPA ID Number: 37-0681517001

Date of Initial License for Current Owners: unable to locate

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Andrea L. McFadden **Telephone Number:** (618)233-2095

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Betty Gibbons
(Title) Interim Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	113	Intermediate (ICF)	113	41,358	3
4		Intermediate/DD			4
5	62	Sheltered Care (SC)	62	22,692	5
6		ICF/DD 16 or Less			6
7	175	TOTALS	175	64,050	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,187	13,786		34,973	10
11	ICF/DD					11
12	SC	2,973	5,432		8,405	12
13	DD 16 OR LESS					13
14	TOTALS	24,160	19,218		43,378	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.73%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	286,927	24,507	7,947	319,381		319,381		319,381			1
2	Food Purchase		200,672		200,672		200,672		200,672			2
3	Housekeeping	197,705	29,350		227,055		227,055		227,055			3
4	Laundry	96,705	15,631		112,336		112,336		112,336			4
5	Heat and Other Utilities			201,728	201,728		201,728		201,728			5
6	Maintenance	70,895	24,559	34,436	129,890	350	130,240		130,240			6
7	Other (specify):*	10,124			10,124		10,124		10,124			7
8	**TOTAL General Services**	662,356	294,719	244,111	1,201,186	350	1,201,536		1,201,536			8
	B. Health Care and Programs											
9	Medical Director			8,125	8,125		8,125		8,125			9
10	Nursing and Medical Records	1,489,147	10,373	26,861	1,526,381		1,526,381		1,526,381			10
10a	Therapy	32,123		7,703	39,826		39,826		39,826			10a
11	Activities	54,335	2,277	1,828	58,440		58,440		58,440			11
12	Social Services	50,759		791	51,550		51,550		51,550			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,626,364	12,650	45,308	1,684,322		1,684,322		1,684,322			16
	C. General Administration											
17	Administrative	75,360			75,360		75,360		75,360			17
18	Directors Fees											18
19	Professional Services			72,643	72,643		72,643		72,643			19
20	Dues, Fees, Subscriptions & Promotions			19,099	19,099		19,099	(8,948)	10,151			20
21	Clerical & General Office Expenses	238,291	17,637	9,592	265,520		265,520		265,520			21
22	Employee Benefits & Payroll Taxes			636,704	636,704		636,704		636,704			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,246	4,246		4,246		4,246			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			113,642	113,642		113,642		113,642			26
27	Other (specify):*			112,717	112,717	(350)	112,367	(22,031)	90,336			27
28	**TOTAL General Administration**	313,651	17,637	968,643	1,299,931	(350)	1,299,581	(30,979)	1,268,602			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,602,371	325,006	1,258,062	4,185,439		4,185,439	(30,979)	4,154,460			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Paul's Home #0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			178,773	178,773		178,773		178,773			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,304	77,304		77,304		77,304			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			256,077	256,077		256,077		256,077			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,590	2,590		2,590		2,590			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,038	62,038		62,038		62,038			42
43	Other (specify):* **Van Driver**	8,763			8,763		8,763		8,763			43
44	**TOTAL Special Cost Centers**	8,763		64,628	73,391		73,391		73,391			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,611,134	325,006	1,578,767	4,514,907		4,514,907	(30,979)	4,483,928			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	8,948	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	22,031	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 30,979		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 30,979		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St. Paul's Home

ID# 0013920

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Newsletter	$ 4,939	27	1
2	IDPA- Civil Monetary Penalty	16,315	27	2
3	Miscellaneous Sundry Items	627	27	3
4	Compliance Ad Cost	75	27	4
5	Finance Charges	75	27	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	22,031		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Paul's Home # 0013920 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	8,948	0	0	0	0	0	0	0	0	0	0	8,948	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	22,031	0	0	0	0	0	0	0	0	0	0	22,031	27
28	**TOTAL General Administration**	30,979	0	0	0	0	0	0	0	0	0	0	30,979	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	30,979	0	0	0	0	0	0	0	0	0	0	30,979	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Paul's Home # 0013920 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	30,979	0	0	0	0	0	0	0	0	0	0	30,979	45

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule page 26						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Union Planters		X	Real Estate Mortgage	$5,486.00	12/13/01	$ 636,144	$ 573,253	12/13/06	7.0600	$ 41,827	1
2	Union Planters		X	Real Estate Mortgage	$540.00	01/04/02	59,498	51,854	12/13/06	7.0600	3,817	2
3												3
4	Interest Income										(53)	4
5	Dividend Income										(132)	5
	Working Capital											
6	Union Planters		X	Provide Operating Funds		07/05/03	125,000		07/05/04	4.5000	4,386	6
7	Union Planters		X	Provide Operating Funds		07/05/04	210,000	210,000	07/05/05	4.5000	5,157	7
8	St. Paul's Foundation	X		Provide Operating Funds		01/01/04	492,500	917,500	01/01/05	3.0000	22,302	8
9	TOTAL Facility Related				$6,026.00		$ 1,523,142	$ 1,752,607			$ 77,304	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,523,142	$ 1,752,607			$ 77,304	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	Exempt	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	Exempt	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	Exempt	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Paul's Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0013920

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,032 B. General Construction Type: Exterior Brick Frame _____ Number of Stories See Pg. 24

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

St. Paul's Home Retirement Community, independent living apartments, 62,500 square feet, 53 apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	178,000	1926	$ 16,901	1
2	Resident Use	Land Improvement	1995	5,310	2
3	TOTALS	178,000		$ 22,211	3

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30		1960	1960	$ 166,566	$	25	$	$	$ 166,566	4
5	32		1957	1957	148,250	2,968	50	2,968		139,357	5
6	38		1962	1962	266,977	5,897	50	5,897		225,697	6
7	75		1971	1971	654,498	15,997	40	15,997		551,582	7
8			1981	1981	718,105	16,833	40	16,833		434,743	8
	Improvement Type**										
9				1961	14,618		25			14,618	9
10				1963	594		25			594	10
11				1971	40,791		25			40,791	11
12				1973	1,471		25			1,471	12
13				1974	1,162		20			1,162	13
14				1975	7,723		25			7,723	14
15				1976	75,275	2,015	35	2,015		62,181	15
16				1977	13,703		10			13,703	16
17				1978	24,680		25			24,680	17
18				1979	454,801	15,160	30	15,160		386,864	18
19				1980	5,908		20			5,908	19
20				1982	44,406	156	10	156		44,406	20
21				1983	6,581		10			6,581	21
22				1984	8,251		10			8,251	22
23				1985	2,786		10			2,786	23
24				1986	17,208	691	20	691		12,641	24
25				1987	169,475	3,972	20	3,972		139,184	25
26				1989	38,131	1,108	15	1,108		37,908	26
27				1991	109,995	4,664	20	4,664		78,290	27
28				1992	54,380	862	10	862		43,616	28
29				1993	6,300	252	25	252		3,024	29
30				1994	45,495	2,990	15	2,990		33,466	30
31				1995	21,589	2,159	10	2,159		21,589	31
32	Repaved parking lot / sidewalk improvements			1996	19,616	1,699	15	1,699		14,441	32
33	Dishroom renovation and door installation			1996	38,379	2,009	20	2,009		17,990	33
34	Remodeled administrative office area			1996	9,218	615	15	615		5,224	34
35	Installation of fences			1996	4,099	410	10	410		3,689	35
36	Supplemental lighting for parking lot			1997	1,225	82	10	82		654	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Asphalt driveway improvements	1997	$ 11,065	$ 851	10	$ 851	$	$ 8,936	37
38	Building for emergency generator	1997	33,000	1,000	33	1,000		8,000	38
39	Structural improvements to Kohl wing	1997	21,878	1,286	20	1,286		9,853	39
40	Installation of fences	1997	1,823	182	10	182		1,367	40
41	Telephone alcove and construction of wall divider	1997	3,690	246	15	246		1,968	41
42	Internal corridor doors	1997	4,118	412	10	412		3,296	42
43	Remodeling / redecorating of resident rooms / areas	1997	29,198	2,856	10	2,856		22,817	43
44	Aluminum ramps / brackets for porch area	1998	1,121		5			1,121	44
45	Tuckpointing / Caulking of retaining wall	1998	2,500	312	8	312		2,031	45
46	Soffitt / fascia installation	1998	13,194	660	20	660		4,288	46
47	Wallcovering (employee dining room and main corridor)	1998	2,765	277	10	277		1,936	47
48	Roof replacement (Kohl wing)	1998	31,078	2,179	10	2,179		14,165	48
49	Remodeling of shower room (Kohl wing)	1998	3,836	384	10	384		2,493	49
50	Roof repairs (Ludwig wing)	1998	1,620	162	10	162		1,053	50
51	Shelter nurses' station renovation	1999	7,194	719	10	719		4,316	51
52	Structural repairs to Kohl wing	1999	1,988	199	10	199		1,193	52
53	Shower stall and flooring replacements (Kohl wing)	1999	4,418	442	10	442		2,651	53
54	Panic hardware for Ludwig front door	1999	527	53	5	53		527	54
55	Bartel wing lighting	1999	5,034	503	10	503		2,769	55
56	Valves for domestic water line	1999	1,927	193	10	193		1,060	56
57	Water supply lines for cooling tower	1999	592	4	10	4		325	57
58	Chapel roof repairs	2000	3,025	302	10	302		1,664	58
59	Bartel wing soiled linen room remodeling	2000	7,860	524	15	524		2,620	59
60	Heater covers for entry main corridor	2000	1,209	121	10	121		544	60
61	Replacement of Bartel wing sewer line	2001	16,237	812	20	812		4,059	61
62	Kitchen lighting project	2001	13,493	675	20	675		2,699	62
63	Exit seeker system	2001	10,767	1,077	10	1,077		4,307	63
64	Ludwig wing sewer project	2001	12,719	636	20	636		2,226	64
65	Master antennae system (Bartel wing)	2001	2,149	215	10	215		752	65
66	Window project (Bartel wing)	2001	22,442	898	25	898		3,142	66
67	Laundry dedicated electrical circuit	2001	840	84	10	84		294	67
68	Fire and smoke doors in Bartel long hall	2002	3,292	219	15	219		658	68
69	Chapel roof repair	2002	25,974	2,597	10	2,597		7,792	69
70	TOTAL (lines 4 thru 69)		$ 3,494,829	$ 101,619		$ 101,619	$	$ 2,678,302	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,494,829	$ 101,619		$ 101,619	$	$ 2,678,302	1
2	Chapel - electrical work	2002	3,450	345		345		1,034	2
3	Kitchen - A/C	2002	1,612	161		161		488	3
4	Kitchen - walk-in refrigerator unit	2002	2,740	274		274		821	4
5	Kitchen - water storage tank replacement	2002	5,145	257		257		771	5
6	Front entry and walk	2002	34,288	2,286		2,286		6,285	6
7	Chapel - A/C unit	2002	8,410	841		841		2,523	7
8	Kitchen - walk-in freezer replacement	2002	4,750	475		475		1,187	8
9	Kitchen range hood electrical shut down project	2003	2,269	151		151		303	9
10	Lamp posts	2003	955	57		57		121	10
11	Front walk project	2003	8,583	858		858		1,717	11
12	West drive project	2003	2,115	212		212		423	12
13	New floor tile and subfloor room 102 Kohl wing	2003	2,135	213		213		320	13
14	Install new metal door for dishroom	2003	1,708	171		171		256	14
15	Fresh air intake for laundry room	2003	5,893	589		589		884	15
16	Repair exterior wall of employee dining room	2003	8,303	830		830		1,245	16
17	Hot water plumbing project	2004	33,937	1,697		1,697		1,697	17
18	Install shower thresholds (Bartel)	2004	1,550	155		155		155	18
19	Repair/Replaster N. & W. walls in employee dining room	2004	3,291	329		329		329	19
20	Wall guards for 12 resident rooms & hand rail main hall	2004	1,313	66		66		66	20
21	Patch walls, ceilings, around windows in resident rooms	2004	13,179	1,318		1,318		1,318	21
22	Replace bad section of cast iron waste line	2004	862	86		86		86	22
23	Install acoustical ceiling in room #209	2004	855	86		86		86	23
24	Kohl wing HVAC air handler heating system	2004	1,937	97		97		97	24
25	Kohl and Ludwig front walk project	2004	1,111	56		56		56	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,645,220	$ 113,229		$ 113,229	$	$ 2,700,570	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 729,968	$ 61,051	$ 61,051	$		$ 422,518	71
72	Current Year Purchases	14,577	1,334	1,334			1,334	72
73	Fully Depreciated Assets	855,660	2,374	2,374			855,660	73
74								74
75	TOTALS	$ 1,600,205	$ 64,759	$ 64,759	$		$ 1,279,512	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van/Improvements	Ford/Van/1985	1985	$ 26,794	$	$	$	5	$ 26,794	76
77	Van/Improvements	Ford/1992/Lift	1995/1996	15,155				5	15,155	77
78	Van/Improvements	Ford/Van/1985	1997	3,240				5	3,240	78
79	Resident Transport	Buick/LeSabre/1995	2002	5,495	785	785		7	1,963	79
80	TOTALS			$ 50,684	$ 785	$ 785	$		$ 47,152	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,318,320	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,773	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,773	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,027,234	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a3	hrs		15	476		15	476	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a3	hrs		220	7,227		220	7,227	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	235	$ 7,703	$	235	$ 7,703	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,958	$ 36,830	1
2	Cash-Patient Deposits	3,959	3,959	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	340,023	351,147	3
4	Supply Inventory (priced at Cost)	19,883	25,699	4
5	Short-Term Investments	1,166	3,836	5
6	Prepaid Insurance	2,213	2,919	6
7	Other Prepaid Expenses	6,166	7,181	7
8	Accounts Receivable (owners or related parties)		929,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 386,368	$ 1,360,571	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,303	1,616,239	12
13	Land	22,696	445,592	13
14	Buildings, at Historical Cost	3,936,625	8,652,827	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,655,162	1,962,118	16
17	Accumulated Depreciation (book methods)	(4,126,984)	(6,305,105)	17
18	Deferred Charges	502	4,368	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,494,304	$ 6,376,039	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,880,672	$ 7,736,610	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 114,809	$ 124,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,688	25,458	28
29	Short-Term Notes Payable	34,163	179,717	29
30	Accrued Salaries Payable	45,315	48,884	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,137	3,137	31
32	Accrued Real Estate Taxes(Sch.IX-B)		5,317	32
33	Accrued Interest Payable	9,559	23,190	33
34	Deferred Compensation	14,578	60,983	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	210,000	210,000	36
37	Advances from NonCare Operations	917,500	929,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,350,749	$ 1,609,847	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	590,944	3,124,024	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation		22,160	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 590,944	$ 3,146,184	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,941,693	$ 4,756,031	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (61,021)	$ 2,980,579	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,880,672	$ 7,736,610	48

***(See instructions.)**

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,843,646	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,843,646	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(607,227)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	620,103	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) See attachement page 27	124,057	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 136,933	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,980,579	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,854,446	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,854,446	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attachment page 27	53,234	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53,234	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,907,680	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,201,186	31
32	Health Care	1,684,322	32
33	General Administration	1,299,931	33
	B. Capital Expense		
34	Ownership	256,077	34
	C. Ancillary Expense		
35	Special Cost Centers	11,353	35
36	Provider Participation Fee	62,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,514,907	40
41	**Income before Income Taxes (line 30 minus line 40)****	(607,227)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (607,227)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not for Profit If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,852	2,104	$ 56,599	$ 26.90	1
2	Assistant Director of Nursing	1,932	2,172	47,821	22.02	2
3	Registered Nurses	6,722	7,444	135,183	18.16	3
4	Licensed Practical Nurses	28,346	31,109	454,114	14.60	4
5	Nurse Aides & Orderlies	76,872	83,702	798,830	9.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,594	3,278	32,123	9.80	8
9	Activity Director	690	761	16,237	21.34	9
10	Activity Assistants	4,173	4,549	38,098	8.38	10
11	Social Service Workers	4,192	4,647	50,759	10.92	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,322	44,182	19.03	13
14	Head Cook	1,824	2,236	22,357	10.00	14
15	Cook Helpers/Assistants	10,162	11,023	95,012	8.62	15
16	Dishwashers	16,013	17,382	125,376	7.21	16
17	Maintenance Workers	7,993	8,699	74,295	8.54	17
18	Housekeepers	23,016	25,288	201,105	7.95	18
19	Laundry	12,050	13,386	96,705	7.22	19
20	Administrator	2,134	2,318	75,360	32.51	20
21	Assistant Administrator					21
22	Other Administrative	2,273	2,445	58,620	23.98	22
23	Office Manager	2,048	2,120	51,269	24.18	23
24	Clerical	11,818	13,182	118,201	8.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) 1/2 Van Dr/Sec	2,264	2,397	18,888	7.88	33
34	TOTAL (lines 1 - 33)	221,059	242,564	$ 2,611,134 *	$ 10.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	132	$ 5,972	1/3	35
36	Medical Director	*	8,125	9/3	36
37	Medical Records Consultant		403	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,750	10/3	39
40	Physical Therapy Consultant	220	7,227	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	476	10/3	43
44	Activity Consultant	33	1,828	11/3	44
45	Social Service Consultant	14	791	12/3	45
46	Other(specify)				46
47	CNA Scheduling Consultant		1,375	10/3	47
48	* = on an as needed basis				48
49	TOTAL (lines 35 - 48)	510	$ 28,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,214	22,334	10/3	52
53	TOTAL (lines 50 - 52)	1,214	$ 22,334		53

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arthur H. Peters	Pres./Admin.	0	$ 75,360
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,360

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 11,389
Greensfelder	Legal Services	26,390
Rice, Sullivan	Audit Services	7,847
FR&R	Operations Review	14,517
BKD, LLP	Operations Review	12,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 72,643

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,919
Unemployment Compensation Insurance	13,702
FICA Taxes	199,752
Employee Health Insurance	315,192
Employee Meals	18,042
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations Expense	2,098
TOTAL (agree to Schedule V, line 22, col.8)	$ 636,705

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,011
Health Care Worker Background Check	
(Indicate # of checks performed 43)	612
Newspapers & Subscriptions	1,708
Life Services Network	5,820
Promotion & Advertising	8,800
Civic Dues	148
Civic Dues	(148)
Less: Public Relations Expense	( )
Non-allowable advertising	(6,615)
Yellow page advertising	(2,185)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,151

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	604
Seminar Expense	3,642
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,246

**See instructions.

Facility Name & ID Number St. Paul's Home # 0013920 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Interior Painting	04/1998	$ 1,720	3	$ 136	$	$	$	$	$	$	$	$
2	Interior Painting	10/1998	763	3	196								
3	Interior Painting	10/1998	2,832	3	699								
4	Interior Painting	12/1998	560	3	160								
5	Interior Painting	01/1999	130	3	34								
6	Interior Painting	01/1999	360	3	120								
7	Interior Painting	01/1999	540	3	180								
8	Interior Painting	04/2000	134	3	48								
9	Interior Painting	09/2000	172	3	60								
10	Interior Painting	09/2000	135	3	48	50							
11	Interior Painting	11/2002	81	3		60	32						
12	Interior Painting	06/2003	605	3		48	23						
13	Interior Painting	04/2003	85	3		4	24	24	24	5			
14	Interior Painting	02/2003	257	3			118	202	202	83			
15	Interior Painting	04/2004	87	3			21	28	28	8			
16							79	86	86	6			
17								22	29	29	7		
18													
19													
20	TOTALS		$ 8,461		$ 1,681	$ 162	$ 297	$ 362	$ 369	$ 131	$ 7	$	$

Facility Name & ID Number St. Paul's Home # 0013920 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $5,820.00**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **8,376** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **62,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **18,042** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,374**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Rice, Sullivan and Company, Ltd.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

St. Paul's Home
IDPH Facility ID #0013920
01/01/04-12/31/04

Attachment to Schedule X, Building and General Information

Schedule X, A, Number of Stories

Nursing Facility is comprised of 6 buildings:
2 Buildings are 2 stories
4 Buildings are 1 story, 3 of which have basements

Attachment to Schdule XI, A, Land, Line 1, Column 4

General Ledger balance of $17,386 reduced to $16,901 by 1982 audit

Attachment to Schedule XIII Expenses Relating to Nurse Aide Training Programs Page 15

St. Paul's Home only hires CNA's that have already completed a certified nurse aides training program and are currently listed in the Illinois CNA registry.

Supplement to Schedule V, Cost Center Expenses

Line 27, Column 4

Newletter	$ 4,939
Sundry expenses and incidental supplies	627
Volunteer recognition	246
"Compliance" ad cost	75
Items to be reclassified	350
Finance Charges	75
Amortization of membership dues in Senior Care Network	90,090
IDPA - Civil Monetary penalty	16,315
	$ 112,717

Line 27, Column 5 - Reclassification

Reclassification to maintenance "other"	$ (350)
	$ (350)

Summary of Miscellaneous Sundry Account, Line 27

Amortization of membership dues in Senior Care Network	$ 90,090
Volunteer recognition	246
	$ 90,336

Reclassification, Column 5

All reclassifications were made to meet requirements set forth in cost report instructions. Original General Ledger distributions were made according to internal accounting polices of St. Paul's Home.

Special Cost Centers, Other, Line 43, Column 1

Salary of van driver to take residents to doctor appointments, hospitals and labs.

St. Paul's Home
IDPH Facility ID # 0013920
01/01/04 - 12/31/04

(Accts 632 & 635)
Supplement to Schedule V, Line 24, Column 3, Travel and Seminar

Attended by: Joni Suemnicht, Administrative Nurse
Suzanne Bragg, Social Services/Activities Director
Sonia Marsenic, Food Services Director
Gay Simpson, LPN
Pam Woodward, Director of Nursing
Date: 01/22, 02/02, 02/12, 02/19, 02/26 & 03/05/04
Location: Belleville, IL
Title: Mastering the MDS
Sponsor: Life Services Network of Illinois
Cost: $ 499.00
Justification: To build MDS proficiency and to improve quality of care and bottom line results.

Attended by: Al Quellmalz, Assistant Maintenance Supervisor
Date: 4/19/2004
Location: St. Louis, MO
Title: Basic Supervision
Sponsor: National Seminars Group
Cost: $ 299.75
Justification: To learn basic supervision skills to boost productivity, morale and quality of employee's work

Attended by: Sonia Marsenic, Food Services Director
Date: 6/10/2004
Location: St. Louis, MO
Title: Nutrition & Dining Services and the Long-Term Care Survey
Sponsor: Cross Country University
Cost: $ 228.39
Justification: To gain valuable knowledge regarding both clinical and management practices.

Attended by: Joni Suemnicht, Administrative Nurse
Date: 5/20/2004
Location: Mt. Vernon, IL
Title: "Dare" Seminar Is you Health Facility at risk for his top ten list?
Sponsor: Illinois Health Care Association
Cost: $ 213.75
Justification: To gain more knowledge relating to MDS regulations.

Attended by: Diane Newton, Housekeeping Supervisor
Tom Sala, Maintenance Supervisor
Date: 6/17/2004
Location: Springfield, IL
Title: OSHA Seminar
Sponsor: OSHA
Cost: $ 95.63
Justification: To gain knowledge regarding accident investigation and analysis.

Attended by: Betty Gibbons, Vice President of Admin. Services
Date: 7/20/2004
Location: Springfield, IL
Title: Workplace Law Update 2004
Sponsor: Life Services Network
Cost: $ 252.00
Justification: To gain understanding of the impact of new FLSA overtime regulations,.

Supplement to Schedule V, Line 24, Column 3, Travel and Seminar (Continued)

Attended by: Mary Neuman, ADON and 4 CNA's
Date: 6/11/2004
Location: Ina, IL
Title: "Front Line Focus" Workshop
Sponsor: Life Services Network
Cost: $ 137.46
Justification: Discussed personal choices for residents and what can be done to keep them happy.

Attended by: Mary Neuman, ADON and 4 CNA's
Pam Woodward, DON
Date: 6/10/2004
Location: Fairview Heights, IL
Title: Discussed motivational tools used to raise job moral and performance.
Sponsor: DON of Metro East
Cost: $ 120.00
Justification: To gain a better understanding of resident employee relationships.

Attended by: Suzanne Bragg, Social Services/Activities Director
Date: 8/10/2004
Location: Mt. Vernon, IL
Title: Illinois' Medicaid Reimbursement
Sponsor: Illinois Healthcare Association
Cost: $ 165.00
Justification: To examine key MDS items and programs tied to reimbursement and quality care.

Attended by: Betty Gibbons, Vice President of Admin. Services
Diane Newton, Housekeeping Supervisor
Date: 8/24/2004
Location: Springfield, IL
Title: Workplace Hazards
Sponsor: Life Services Network
Cost: $ 121.25
Justification: To learn how to improve workplace safety and decrease workplace hazards.

Attended by: Suzanne Bragg, Social Services/Activities Director
Sonia Marsenic, Food Services Director
Date: 10/7/2004
Location: Springfield, IL
Title: Illinois Pioneer Coalition Summit
Sponsor: Illinois Pioneer Coalition Facilitator
Cost: $ 487.70
Justification: To improve quality of life for residents.

Attended by: Mary Neuman, ADON
Pam Woodward, DON
Date: 10/13/2004
Location: Fairview Heights, IL
Title: DON Fall Conference
Sponsor: DON of Metro East
Cost: $ 100.00
Justification: Discussed sensitivity issues and geriatric issues.

Supplement to Schedule V, Line 24, Column 3, Travel and Seminar (Continued)

Attended by: Betty Gibbons, Vice President of Admin. Services
Date: 11/5/2004
Location: Belleville, IL
Title: MDS Reimbursement System Eye Opener
Sponsor: Life Services Network
Cost: $ 115.00
Justification: Seminar focuses on reimbursable areas of activities of daily living, restoratives including active and passive range of motion, pain management and nutrition.

Attended by: Betty Gibbons, Vice President of Admin. Services
Date: 11/30/2004 and 12/08/2004
Location: Belleville, IL
Title: Feeling Secure about HIPPA Security.
Sponsor: Life Services Network
Cost: $ 185.00
Justification: To learn how to implement a comprehensive ongoing security plan.

Attended by: Betty Gibbons, Vice President of Admin. Services
Pam Woodward, Director of Nursing
Kim Cornell, Activities Director
Shirley Sala, Office Supervisor/Accountant
Diane Newton, Housekeeping Supervisor
Date: 11/18/2004 and 11/19/2004
Location: Decatur, IL
Title: LSN Transformation Experience
Sponsor: Life Services Network
Cost: $ 1,046.55
Justification: to discuss, planning and skill-building activities that will advance culture change efforts.

Miscellaneous Travel and Seminar expenses	$ 322.65
Total Seminar and Travel Expenses	3,923.50
	$ 4,246.15

St. Paul's Home
IDPH Facility ID #0013920
01/01/04-12/31/04

Attachment to Schedule VII, Related Parties

St. Paul's Home Board of Directors

Mr. William Lindauer, Chairperson
Mr. Richard Binder, Vice Chairperson
Mr. Belmont Valentine, Treasurer
Mr. Robert Ganschinietz, Secretary
Mr. Bob DeCamp, Director
Mr. Thomas Mentzer, Director
Mrs. Kristine Mueller, Director
Mr. Cary Smith, Director
Mrs. Jan Wiggs, Director
Rev. Andrew Kramer, Director

All Officers and Directors listed above receive no compensation and serve on a voluntary basis and donate whatever time is necessary on a part-time basis.

Attachment of Schedule XX, General information, Page 23, Number 12

Salary of van driver to take residents to doctors, labs and hospitals.

St. Paul's Home
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01/01/04-12/31/04

Attachment to Schedule XV, Balance Sheet, Line 34, Column 1

Account title should be Deferred Revenue, not Deferred Compensation

Attachement to XV, Balance Sheet, Line 42, Column 2

Account title should be Deferred Revenue, not Deferred Compensation

Attachment to Schedule XVI, Statement of Changes in Equity - Line 15

Apartment Community Operations	$ 9,946
Foundation (net of bequests, memorial gifts and appeals)	138,576
Non care related property (net)	(22,383)
	$ 126,139

Attachment to Schedule XVII, Other Income, Line 28, Column 1

Activity Income	$ 331
St. Paul's Home Foundation Administrative Support Income	48,000
Miscellaneous Other Income	4,478
Late Fee Income	425
	$ 53,234

St. Paul's Home
IDPH Facility ID #0013920
01/01/04-12/31/04

Summary of Legal Services (copies of invoices attached)

Statement for legal services rendered through January 31, 2004	
Legal services regarding corporate, resident and employee matters.	$ 2,414.53
Statement for legal services rendered through February 29, 2004	
Legal services regarding corporate, resident and employee matters.	1,074.30
Statement for legal services rendered through March 31, 2004	
Legal services regarding corporate, resident and employee matters.	2,469.17
Statement for legal services rendered through May 31, 2004	
Legal services regarding corporate, resident and employee matters.	4,038.05
Statement for legal services rendered through June 30, 2004	
Legal services regarding corporate, resident and employee matters.	980.50
Statement for legal services rendered through July 31, 2004	
Legal services regarding corporate, resident and employee matters.	270.25
Statement for legal services rendered through August 31, 2004	
Legal services regarding corporate, resident and employee matters.	102.50
Statement for legal services rendered through October 31, 2004	
Legal services regarding corporate, resident and employee matters.	1,794.69
Statement dated November 1,2004	
Long Distance Telephone on matters pertaining to St. Paul's Home	44.10
Statement for legal services rendered through December 31, 2004	
Legal services regarding corporate, resident and employee matters.	13,201.90
TOTAL LEGAL SERVICES:	$ 26,389.99